

Dr. Litzmann's conclusions may be taken, we think, as representing the present state of our knowledge on this subject, and at present his conclusions as to practice are sound. Nevertheless, we hope that advancing knowledge and surgical enterprise may soon oblige us to reconsider the accepted conclusions on this point. We hope that those who deviate from the safe and customary line of practice will be careful to publish in detail the results of all their cases.—*Med. Times and Gazette*, May 21, 1881.

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#### *Inversion of the Uterus.*

Dr. ATTHILL, at a recent meeting of the Obstetrical Society of Dublin (*British Medical Journal*, April 16, 1881), read a paper on this subject, in which he treated of its causes, symptoms, and treatment. There were no affections of the uterus in which errors of diagnosis were more frequently made. In four out of five cases which had come under his observation, the existence of inversion was not at first suspected; and in three of them, an attempt was made to remove the tumour, which was supposed to be a polypus, the operation being in each case stopped on account of the pain which the action of the *écraseur* caused. He doubted the correctness of the statement made by Dr. Barnes, that a large majority of cases of inversion followed immediately on delivery.

Of the five cases which he took as the test of his communication, only two occurred after delivery; in the other three, it was due to the presence of a fibrous tumour attached to the fundus of the uterus; moreover, the tumour was in each case sessile, and attached very nearly at the centre of the fundus uteri. He had never seen inversion caused by a pedunculated tumour, or by one attached elsewhere than at the centre of the fundus. So also he had found that, in those cases in which inversion occurred immediately after the conclusion of the second stage of labour, and in which the placenta remained adherent till after the accident had occurred, it was invariably attached to the very fundus. He, therefore, concluded that, "in all cases of inversion of the uterus, whether induced by the presence of a tumour, or occurring as a sequence of labour, the condition was the same in both to this extent, a body, which to all intents was a foreign body, was attached to that part of the uterus which lay between the opening of the Fallopian tubes."

He dissented from the views of those writers who held that the inversion occurring immediately after delivery was due to the weakened condition of the uterine wall at the site of the placental attachment, so long as the placenta remained adherent; and, from the record of cases in which the placenta was found to be adherent after inversion had taken place, it was evident that the inversion frequently—and, in his opinion, probably always—must at least have commenced before the placenta was separated from its attachment. The same remarks applied to tumours of the uterus; nor could he believe that their weight had any real effect in dragging down the fundus. In the case of fibroids, therefore, a further cause, viz., the occurrence of expulsive uterine contractions, was requisite to induce inversion. The fundus was that portion of the uterus most susceptible of irritation, and any foreign body brought into contact with the fundus speedily excited contraction. The presence, therefore, of a tumour attached to the fundus centrally, or of the placenta similarly located, might fairly be presumed to have a tendency to induce expulsive uterine action, which, failing to detach and expel the tumour or placenta, ends in depression and inversion of the fundus; but, for this to occur, he deemed it necessary that the tumour should spring from the fundus, or, if it occurred after parturition, the placenta should be attached nearly centrally to the same portion of the intra-uterine surface.

In reply to the objection which might be raised to this theory of the cause of

inversion, viz., that, if the attachment of the placenta to the fundus were a cause prone to induce inversion, it should be of more frequent occurrence as a sequence of parturition than it was, he stated his belief that Dr. Barnes was mistaken when he asserted that the most natural position for the attachment of the placenta was the fundal one. In his opinion, on the contrary, as the cervical zone was a dangerous placental site, from the tendency to the occurrence of hemorrhage before delivery, so the fundal zone was also an abnormal placental site; and, if the attachment there were central, it became dangerous, as tending to the possible occurrence of inversion from (1) weakening of the part which it was of importance should be firm, and (2) from the risk of the placenta, if not rapidly detached, acting as a stimulus and exciting uterine contractions, which, as in the case of the sessile fibroids, ended in depression of the weak part, and finally in inversion of the fundus. The term "active spontaneous inversion" used by Dr. Duncan, might, he thought, be fairly applied to cases produced in the manner described; only, instead of paralysis of the placental site, he, Dr. Atthill, considered abnormal activity of the muscular fibre of the part to be the distinctive feature of the case.

Dr. Atthill then read the notes of an interesting case of inversion of the uterus, which had been mistaken for polypus on first examination. It occurred in an unmarried woman aged 47. After removal of a sessile fibroid from the fundus, as the uterus resisted all his efforts to repose it, made with Aveling's and White's instruments, he determined to amputate it, to prevent the danger of subsequent attacks of hemorrhage. Although he believed that reposition of an inverted uterus was, in almost all cases, possible, and was usually advisable, he considered that the conditions of the case he had read rendered amputation of the uterus more advantageous to the woman, and less dangerous than the protracted manipulation which would have been necessary to effect its permanent restoration to the normal position. She was unmarried, and had passed the age of probable child-bearing; and the tumour was so vascular, that even digital examination produced profuse hemorrhage.

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*Estirpation of the Uterus through the Vagina.*

Dr. MARTIN (Berlin) relates the history of twelve cases in which he had extirpated the uterus through the vagina. In three cases, the cervix uteri was alone affected; in eight, it was much enlarged and softened; in three, there was adenomatous growth with cancerous masses in the uterine mucous membrane, which caused severe hemorrhage. In four cases only had the uterus retained its normal mobility. As the organ could generally not be drawn down, Dr. Martin operated *in situ*. After irrigating the vagina with a lukewarm solution of carbolic acid, he made an opening into Douglas's space, and fastened the peritoneum by suture to the edges of the vaginal wound. He then made an anterior incision, separated the uterus from its bed of connective tissue as far as its middle, and tilted the organ backwards by means of a hook. This was done more easily when the uterus was made to glide over a spatula introduced into Douglas's space. The broad ligaments were now tied and divided, and the urinary bladder was set free. The hemorrhage attending this proceeding was very slight. The separation of cancerous nodules from the parametrium was not difficult. In four cases the operation was not completed, in consequence of the great extent of the disease and of the existence of inflammatory adhesions of the uterus in front. In one only was there slight injury of the urinary bladder. The ureters were not injured. A drainage-tube having been introduced into Douglas's pouch, the wound was left open, and the vagina was plugged with salicylated cotton-wool and irrigated on the second day. Of the eight cases in which the operation was complete, six